# Healthcare Industry Standardization

9 August 2006

## Agenda

➢ Introduction

➢ The Current Consumer Experience and Challenges

➢ Financial Services Case Study

➢ The Ideal Consumer Experience

➢ Standards to Enable that Experience

➢ A Starting Point

# Introduction

## ➢ Exante Financial Services

- Founded in 2003 by UnitedHealth Group
- Exclusively dedicated to Medical Banking.
- Provide services to 20 Health Insurance Companies including UnitedHealth Group
- Largest Healthcare bank in the US with more than one million financial healthcare accounts
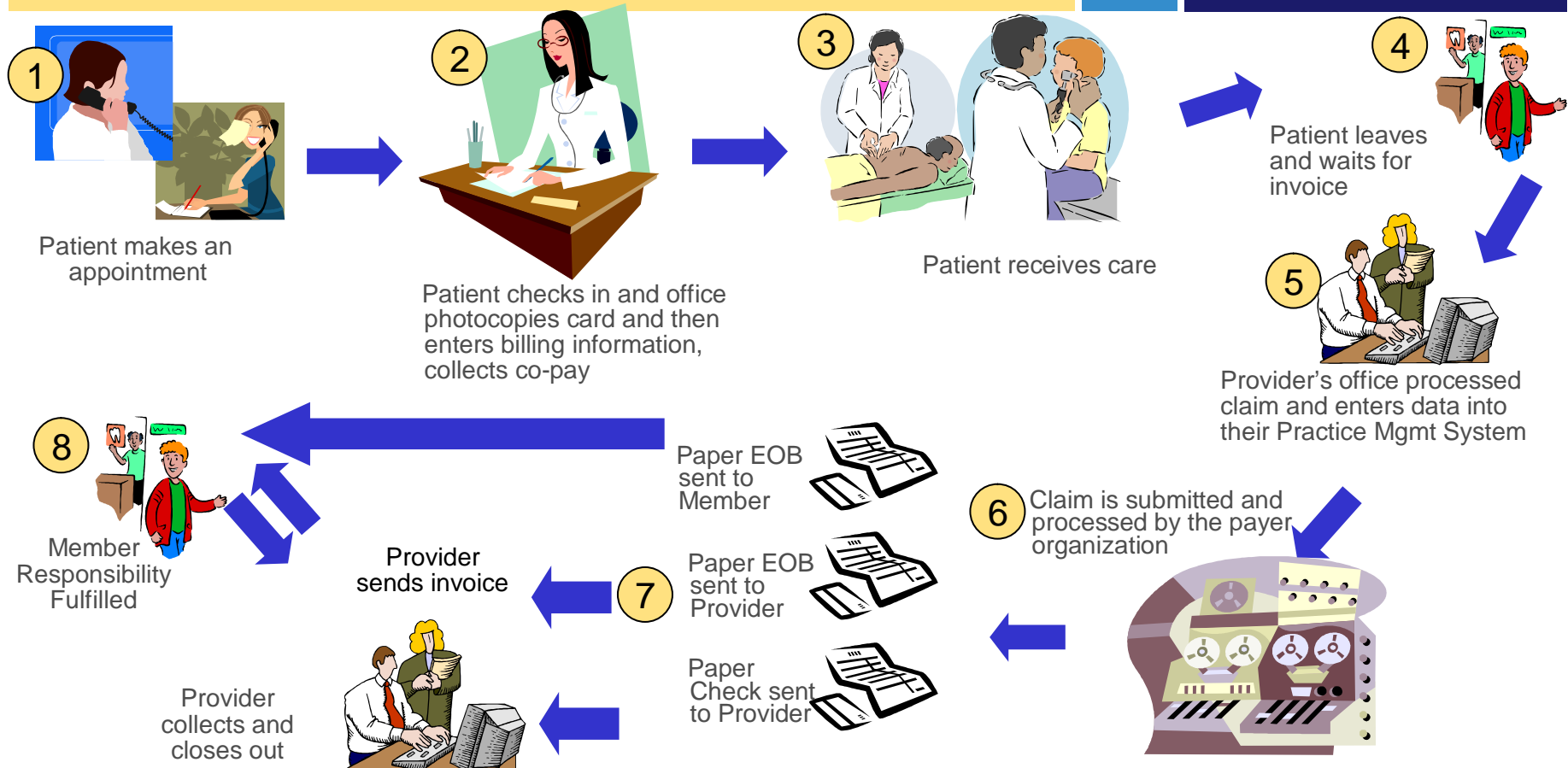
## ➢ John Prince – CEO Exante Financial Services

- Joined Exante in 2005 from JP Morgan Chase
- Led Medical Banking Segment

## ➢ Bill Reboul - VP, Specialty Operations

- Joined UnitedHealth Group in 2003 and Exante in 2005
- Responsible for the strategic direction and operational aspects related to manufacturing of the Health Care Identification Cards

# Current Healthcare Customer Experience

**1** Patient makes an appointment

**2** Patient checks in and office photocopies card and then enters billing information, collects co-pay

**3** Patient receives care

**4** Patient leaves and waits for invoice

**5** Provider's office processed claim and enters data into their Practice Mgmt System

**6** Claim is submitted and processed by the payer organization

Paper EOB sent to Member

Paper EOB sent to Provider

**7** Provider sends invoice

Paper Check sent to Provider

Provider collects and closes out

**8** Member Responsibility Fulfilled

✓ Processing claims expensive and complicated

✓ End-to-End consumer experience is highly paper intensive and inefficient

✓ There is no single "key" to initiate any transactions

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➢ There are significant numbers of claims that are rejected[1]

  – There are nearly 15 Billion claims submitted annually

  – 30% of those claims are rejected upon submission

  – 15% are never resubmitted

  – A conservative estimate of the rework associated with rejected claims is in excess of $10 billion nationally

➢ A study sponsored by the Mid America Coalition on Healthcare analyzed the root causes for these rejections

  – More than 50% of the rejected claims are caused by missing or inaccurate information

➢ The primary source of member information is the Medical Identification Card

[1] Med News "Insurance Claim Denials are Money Left Behind." 3rd quarter 2002 and UnitedHealth Group Analysis

## Case Study: Transformation of the Financial Services Industry

**In 1980 it took over 15 days to clear a trade, by 2006 this gap dropped to 1 day in most cases and Straight Through Processing is becoming a reality.**



Source: DTCC, SIA, NYSE, UnitedHealth Group Analysis
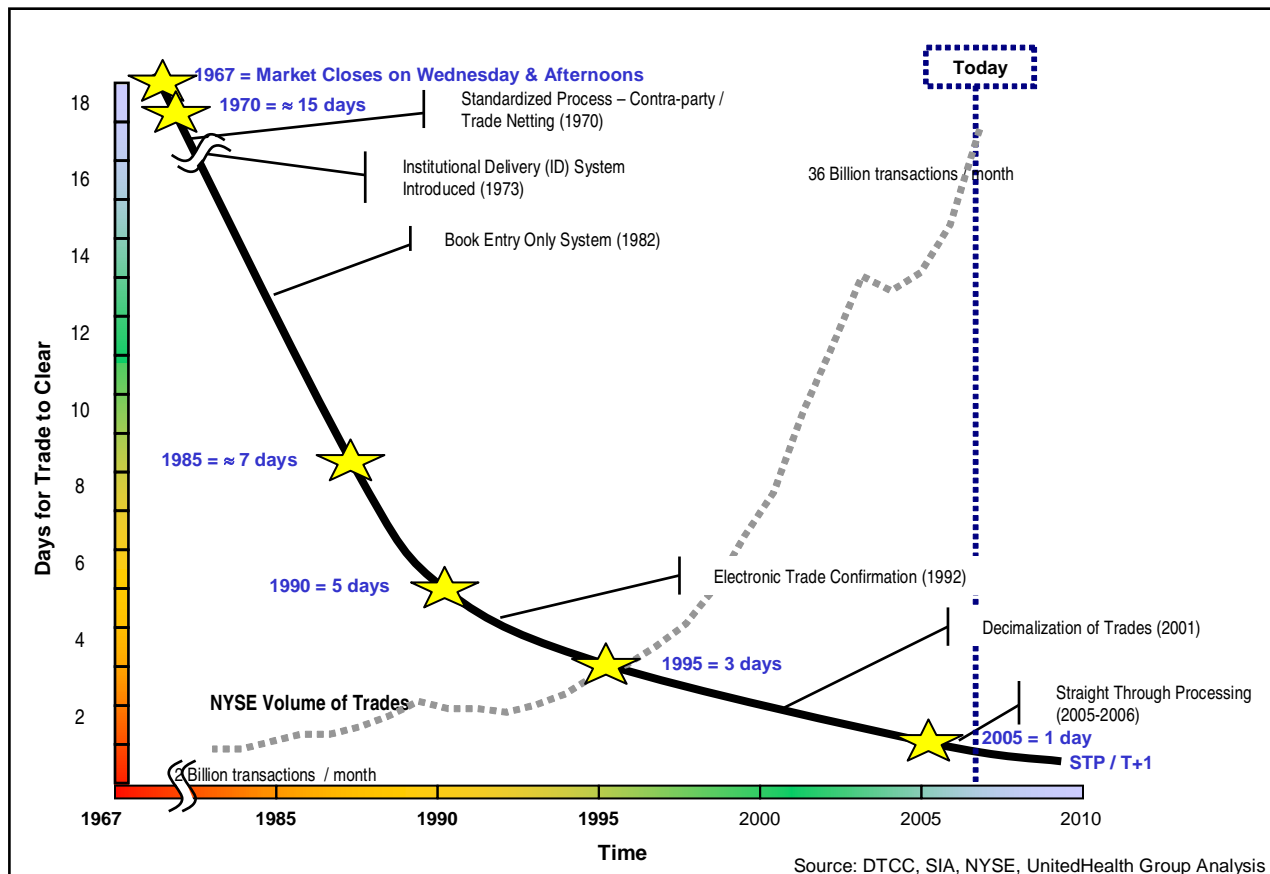
**The Financial Services Industry accomplished this transformation through three actions…**

1. Standardizing Process & Information
2. Enabling Technology
3. Significant Culture Change

**…that resulted in the following benefits:**

1. Reduced Trade Failures
2. Ability to handle increasing volume
3. Reduction in headcount / significant operational consolidation
4. Elimination of paper certificates

# Guiding Design Principles

➤ **Process:**

  – The process needs to be cost effective to allow all size offices to utilize any new solution

  – The process must have a compelling enough value proposition to make a provider's office change behavior
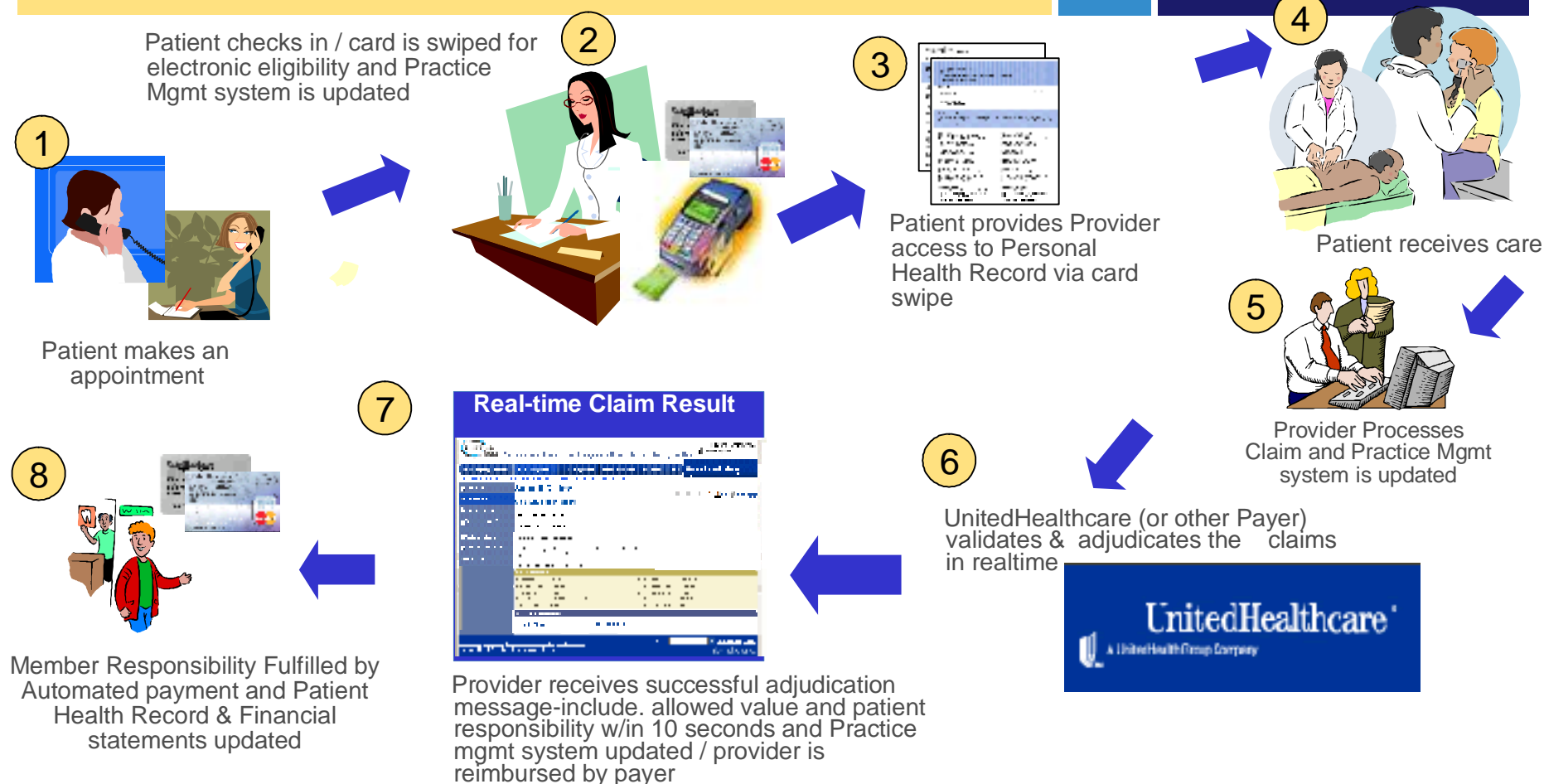
➤ **Information:**

  – Cards will serve as a "key" or access mechanism. They will not carry information beyond what is necessary to allow a registered and approved user access information residing in the system of a Payer

  – Information needs to be standardized and interoperable to support initiation of most HIPAA required transactions

➤ **Technology:**

  – All technology deployed needs to support self service capabilities

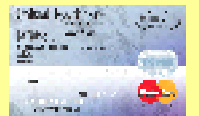  – All technology deployed needs to be simple enough to maintain by the provider.

# The Future Customer Experience



Patient checks in / card is swiped for electronic eligibility and Practice Mgmt system is updated

**1** Patient makes an appointment

**2**

**3** Patient provides Provider access to Personal Health Record via card swipe

**4** Patient receives care

**5** Provider Processes Claim and Practice Mgmt system is updated

**6** UnitedHealthcare (or other Payer) validates & adjudicates the claims in realtime

**7** Real-time Claim Result

Provider receives successful adjudication message-include. allowed value and patient responsibility w/in 10 seconds and Practice mgmt system updated / provider is reimbursed by payer

**8** Member Responsibility Fulfilled by Automated payment and Patient Health Record & Financial statements updated

Much of the technology exists in spot solutions however the common **interoperable** information standard has not been defined

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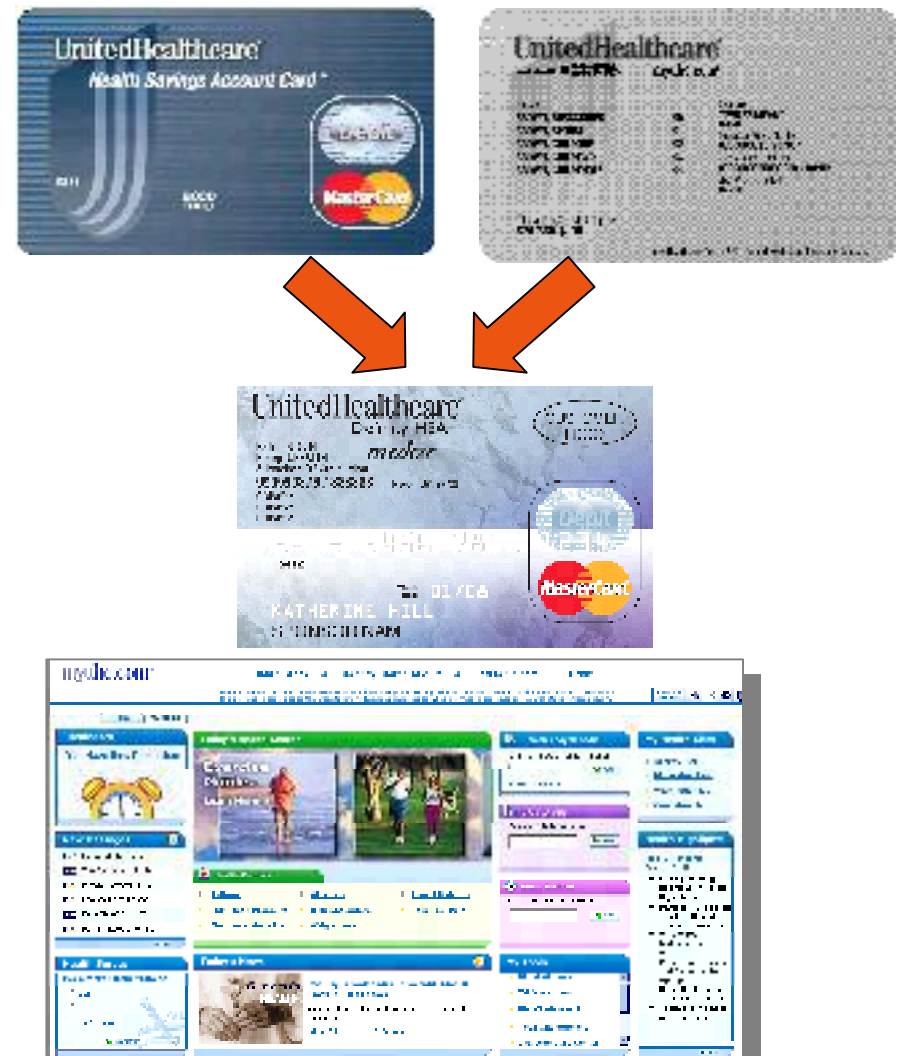# Exante Financial Services Card Portfolio

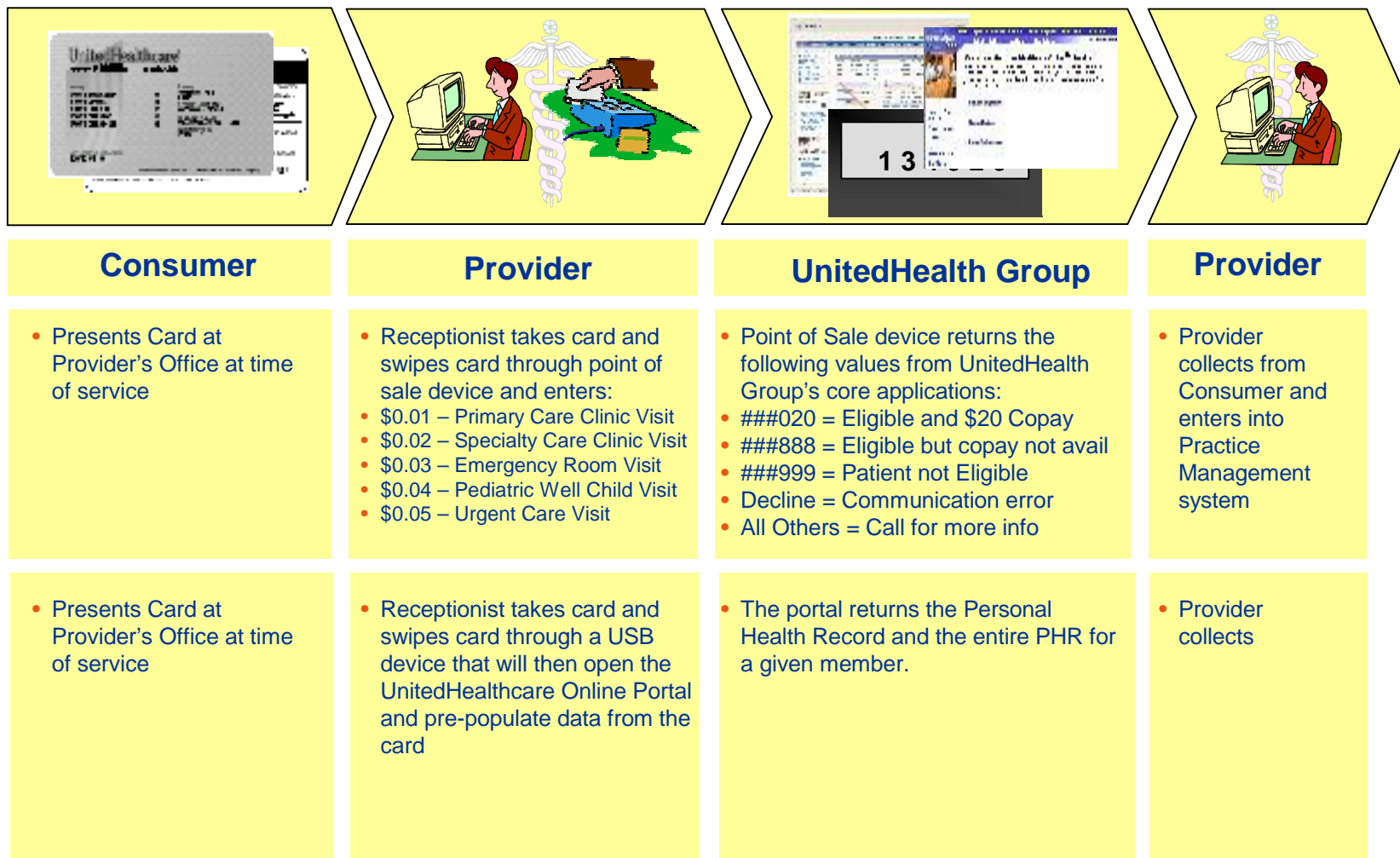| Card Type | Healthcare Account Card | Health Savings Account Card | Consumer Account Card | Integrated Card |
|---|---|---|---|---|
| **Status / Deployment Date** | • In Market<br>• 10/2003<br>• (18 Million) | In Market<br>12/2004<br>(160,000) | In Market<br>12/2003<br>(175,000) | Development<br>2007<br>(TBD) |
| **Type / Specification** | • Medical ID<br>• 30 Mil Teslin | • Financial<br>• 30 mil PVC | • Financial<br>• 30 mil PVC | • Financial &<br>Medical ID<br>• 30 mil PVC |
| **3 Track Magnetic Stripe** | ✓ | ✓ | ✓ | ✓ |
| **Liked to Eligibility** | ✓ | | | ✓ |
| **Linked to Personal Health Records** | ✓ | | | ✓ |
| **Multi-Purse Capable** | | ✓ | ✓ | ✓ |

## Integrating the Consumer Experience



- ◆ **Step 1 – an integrated Medical ID, HSA all on one card with reduced Information**

- ◆ **Staged future evolution including:**

  - – Line of Credit

  - – Single consumer card for medical ID and eligibility

  - – Integrated purse management (HSA, FSA, HRA, and Line of Credit)

  - – Personal Health Record – connected to www.unitedhealthcareonline.com.

  - – Real time adjudication for physician claims

# Improving the Provider/Consumer Experience



|  | **Consumer** | **Provider** | **UnitedHealth Group** | **Provider** |
|---|---|---|---|---|
| **POS Device** | • Presents Card at Provider's Office at time of service | • Receptionist takes card and swipes card through point of sale device and enters:<br>• $0.01 – Primary Care Clinic Visit<br>• $0.02 – Specialty Care Clinic Visit<br>• $0.03 – Emergency Room Visit<br>• $0.04 – Pediatric Well Child Visit<br>• $0.05 – Urgent Care Visit | • Point of Sale device returns the following values from UnitedHealth Group's core applications:<br>• ###020 = Eligible and $20 Copay<br>• ###888 = Eligible but copay not avail<br>• ###999 = Patient not Eligible<br>• Decline = Communication error<br>• All Others = Call for more info | • Provider collects from Consumer and enters into Practice Management system |
| **USB Device** | • Presents Card at Provider's Office at time of service | • Receptionist takes card and swipes card through a USB device that will then open the UnitedHealthcare Online Portal and pre-populate data from the card | • The portal returns the Personal Health Record and the entire PHR for a given member. | • Provider collects |

# A proposed standard for Interoperability

➤ Track 1 & Track 2: Encoded to financial institution standards

➤ Track 3: Encoded to a inter-operable standard

**Medical ID Card  - Data Spec for Third Track**

| | Bytes | |
|---|---|---|
| Start Sentinal | 1 | |
| Separator | 1 | |
| Payer ID | 15 | - zero fill if actual is smaller |
| Separator | 1 | |
| Subscriber ID (Cardholder Id Number) | 20 | - zero fill if actual is smaller |
| Separator | 1 | |
| Group/Policy ID | 15 | - zero fill if actual is smaller |
| Separator | 1 | |
| Rx BIN | 6 | - zero fill if actual is smaller |
| Separator | 1 | |
| Rx Group | 8 | - zero fill if actual is smaller |
| Separator | 1 | |
| Card Issuance Code | 5 | |
| Separator | 1 | |
| LCR | 1 | |
| End Sentinel | 1 | |
| | **79** Spec Max | |
| | **82** Track Available | |

➤ This standard is similar to the one proposed by WEDI and would support NCPDP needs

# Real Time Adjudication Experience

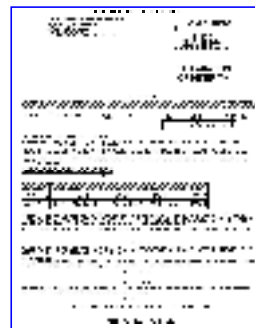**2.** Provider creates and submits claim in real time



**UnitedHealthcare Online Claim Entry**

**1.**
Patient Receives Care

**3.**

UnitedHealthcare validates and adjudicates the claim in real time

**UnitedHealthcare Online Real-time Claim Result**

**4.**

Provider receives successful adjudication message – allowed value and patient responsibility within 10 seconds…

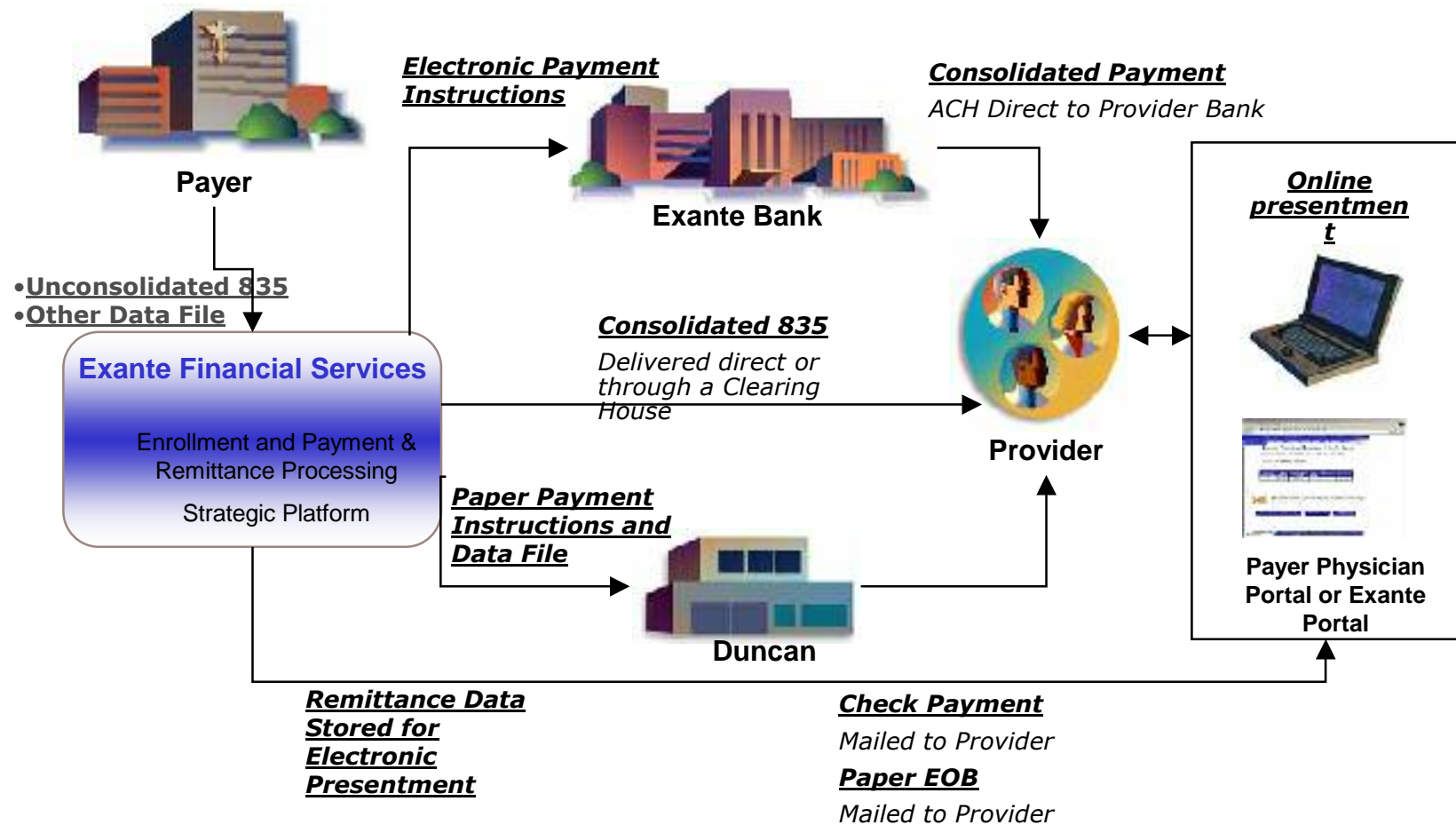If claim is not adjudicated, receives acknowledgment and claim ID

**5.**
Patient receives print detail of the claim, benefit and patient responsibility

# Electronic Payments and Statements

United Health Group

| What is EPS | Value Proposition | Adoption |
|---|---|---|
| ➢ Electronic version of paper EOB and check<br><br>➢ Leverage the HIPAA 835 transaction set<br><br>➢ Deliver electronic payment through the ACH Banking network<br><br>➢ Deliver remittance (835) through provider portal and clearinghouse | ➢ Payers – Electronic payment, electronic remittance delivery through multiple delivery channels, online enrollment<br><br>➢ Providers – Self-service, electronic payment, electronic or web remittance | ➢ 6.2M EOB's converted in 2005<br><br>➢ 11.3M EOB's converted 2006 YTD<br><br>➢ Over 12,000 provider TIN's currently enrolled<br><br>➢ 9,00 new enrollments 2006 YTD |

**Payer**

•Unconsolidated 835
•Other Data File

**Exante Financial Services**

Enrollment and Payment &
Remittance Processing

Strategic Platform

*Electronic Payment Instructions*

**Exante Bank**

*Consolidated Payment*
*ACH Direct to Provider Bank*

*Consolidated 835*
*Delivered direct or through a Clearing House*

**Provider**

*Paper Payment Instructions and Data File*

**Duncan**

*Remittance Data Stored for Electronic Presentment*

*Check Payment*
*Mailed to Provider*
*Paper EOB*
*Mailed to Provider*

*Online presentment*

**Payer Physician Portal or Exante Portal**

# Personal Health Record for Consumers

➤ One-click access

➤ Available to consumers and providers via self-service portals

➤ Provides real-time access to Claim, Rx and Lab Information

➤ Secure access via card swipe or member ID

# Health Care Statement



## Replacing multiple EOB's, adding personalized communications

- **Monthly Health Statements contribute to individualized activation by providing personalized messages designed to yield better health and financial outcomes**
- **Clinical member messages augment what has traditionally been only financial information**
- **Available online and by mail**
- **Sample of clinical messages:**
  - Non-urgent ER utilization
  - Common chronic condition programs, such as back, diabetes, and heart
  - Premium Program value
  - Prescription drug savings
  - Preventive care reminders